

CA Department of Health Care Services

Via email to info@calduals.org

May 2, 2013

Re: Comments on Draft Health Risk Assessment Health Plan Guidance

Thank you for the opportunity to comment on the draft Health Risk Assessment (HRA) Health Plan Guidance document that was recently released by the California Department of Health Care Services (DHCS) on April 16, 2013. The Disability Rights Education and Defense Fund (DREDF) is a leading national law and policy center that advances the civil and human rights of people with disabilities through legal advocacy, training, education, and public policy and legislative development.

We recognize that the department is under a very tight deadline to finalize the HRA, and that our comments will be received after the April 30 2013 deadline for finalization stated in the state's Duals' Demonstration Project MOU with the Centers for Medicare and Medicaid Services (CMS). Nonetheless, in the hope that DHCS is making every attempt to give itself sufficient time to fully absorb and incorporate stakeholder comments that were not due until April 30, we wanted to first register our support for the excellent comments submitted yesterday by NSCLC, and second submit a few additional comments and recommendations on some specific aspects of the draft HRA.

1. Clarify HRA Purpose and Process

The guidance refers to the HRA as "the starting point for developing the enrollee's individual care plan" while also quoting from the MOU to describe the HRA as "an in-depth assessment process to identify primary, acute, long-term supports and services, and behavioral health and functional needs." There appears to be some discrepancy between describing the HRA as a "starting point" when the MOU describes "an in-depth assessment process." The discrepancy is perhaps resolved if the HRA described in this Health Plan Guidance is only a preliminary gateway that, depending on the HRA's result, may lead plans to administer additional specialized assessment tools that will, in their totality, comprise an "in-depth assessment process."

Such an approach subjects the HRA tool to many conflicting interests. If it is only supposed to function as a one-time "snapshot" of an individual's health, then it could ostensibly be short and filled out independently or over the phone by many beneficiaries. However, if HRAs are intended to be the primary trigger for undergoing more in-depth future assessments of health and community-based needs, then the HRA must dive more deeply into a beneficiary's current state of health and functional status within the community. A single HRA instrument allows needs assessment to be standardized across all beneficiaries and can function as a check on the plans' preliminary stratification of new enrollees, but how can a single short HRA be generally and accurately used across a wide gamut of functional impairments and living situations?

Advocates have not been given the impression that the HRA is merely a glorified and more officially sanctioned stratification tool and would be deeply disappointed if that turned out to be the case. The timelines provided in the guideline are only acceptable if they refer to the time within which beneficiaries must have their actual and full range of health and community care needs identified and met, not if they refer only to the *initiation* of a more prolonged in-depth assessment process and set of tools that receives less or no public comment. DREDF would also strongly oppose beneficiaries potentially being made to undergo repeated layers of plan assessment, with the assessment tools growing increasingly specialized and opaque.

2. HRA Standard Assessment Questions Must Address Long-Term Supports and Services (LTSS) Needs

The guidance specifically mentions the SF-12 as a source for standard assessment questions, but the SF-12 (and SF-36) appears to be primarily a quality outcomes measurement and research tool that enables comparisons within a population across different points in time, or comparisons across populations. The response choices are generally dichotomous (a two-point “yes/no”) rather than a more nuanced multiple point response choice. The health “snapshot” that it provides is imprecise. This can be overcome in the research context by using a large sample sizes to improve the confidence intervals for group averages in health scores. The imprecision cannot be overcome if the questions are intended to solicit information about an *individual’s* health, service, and support needs rather than a large group’s population profile or average health outcomes.

Even if the reference to the SF-12 is simply intended to illustrate the kind of topics and framing that will be included among more precise RA standard assessment questions that are still being developed, there is still the issue that the SF-12 does not encompass LTSS needs. With the assumption that the department fully intends to include LTSS needs assessment within the HRA and the Health Plan Guidance timelines, we would like to highlight just a few additional assessment tools that could be used to identify LTSS needs. DREDF is not necessarily endorsing the use of any one of these tools, but they are rich resources for developing HRA standard assessment questions that will appropriately delve into what can be complex and unmet clinical and LTSS needs. Some have been developed and used for many years in the Developmental Disabilities community.

- Minimum Data Set (MDS): The MDS is a CMS mandated assessment of all residents in Medicare or Medicaid certified nursing homes, assessing each individual’s functional capabilities, and helping nursing home staff to identify health problems.
- Minimum Data Set-Home Care (MDS-HC): The MDS-HC is a validated assessment tool created by interRAI Corporation that was modeled after the MDS. It was developed to assist agencies in identifying the needs, preferences, and strengths of elderly clients living in the community, although it may also be used for adults with disabilities. Several states are using this instrument for HCBS services.

- Inventory for Client and Agency Planning (ICAP): The ICAP is a standardized assessment instrument that measures adaptive and maladaptive behavior. It can be used for both children and adults.
- Continuity Assessment Record and Evaluation (CARE): The CARE Tool was designed for implementation with Medicare populations, primarily those who are aging and /or have physical disabilities. It was developed for use in acute and post-acute-care (PAC) settings participating in the PAC Payment Reform Demonstration.
- Outcome and Assessment Information Set (OASIS): The OASIS tool collects data that can be gathered across home health agencies in a standardized manner, to improve the quality of services using outcomes-based quality improvement methods.

3. Standardize HRA Use

The Medi-Cal only population in the Coordinated Care Initiative (CCI) has levels of health and service needs that are similar to those found in the dually-eligible population. Moreover, individual beneficiaries over time can move from Medi-Cal-only eligibility to acquire dual eligible status. Since a fundamental premise of the CCI is to improve care coordination across beneficiary categories and funding streams, it would be logical to use the same HRA across the entire CCI population. This would enable beneficiaries and consumers to avoid undergoing multiple assessments that serve only specific purposes and solicit information that cannot be transferred from one context to another because each context requires its own specific tool. It will also facilitate the incorporation of the HRA as a health outcome measure for beneficiaries over time and through eligibility for different aspects of the CCI.

4. Accessibility

DREDF strongly recommends that the accessibility requirements of federal and California law be fully incorporated into the HRA Health Plan Guidance. This will require participating health plans not only to document and report generally on their HRA outreach as indicated on page 1 of the Guidance, but to document and report on how and whether members were notified of their right to effective communication and reasonable accommodations and policy modifications in the HRA process, as well as how the plan met the exercise of those rights. Plans need to demonstrate that they have explicit practices, policies, procedures, and representative training in place to accommodate the needs of people with various disabilities who need to schedule and undergo an HRA, including the methods and procedures that plans will pursue to ensure accommodation in the event that a sub-contracted entity fails to follow accessibility requirements during the HRA process.

5. Available to Beneficiary for Review and Correction

DREDF supports the department's clear position that all beneficiaries will be notified of their right to request an in-person HRA, and any beneficiary can make this request regardless of his or her initial stratification status. We would like to point out that this right is only truly significant when the HRA is, in fact, a more in-depth tool that accurately determines the level of a beneficiary's health and LTSS needs. A superficial tool that is administered in person by a perceptive evaluator in a beneficiary's home may gather more information compared to the same tool administered over the phone, but it remains a superficial tool.

One of the advantages of the SF-12 is that it is intended to capture the consumer's own voice, and the right of any beneficiary to request an in-person HRA presumably raises the likelihood that this voice is accurately and thoroughly captured. Those same arguments support extending a right to any beneficiary to request and receive an accessible copy of the completed HRA and the plan's recommendations for meeting the beneficiary's health-related needs. This will enable the beneficiary to check on the accuracy of the information provided, and give him or her an opportunity to correct any mistakes in the HRA and/or share any additional needs that were not captured, especially the home and community-based service needs that are least familiar to many participating plans. Furthermore, those who actually exercise this right and receive a copy of their HRA would provide a particularly informed pool of beneficiaries that could provide the department with invaluable information and feedback concerning not only the HRA process, but the accuracy of the HRA itself as a tool for capturing a wide range of health and functional needs. Essentially, this group is a unique source of information on outcome measures relating to a critical point in the transition process.

6. HRA Use in Institutions

While DREDF advocates for the consistent use of a single HRA tool/process across the CCI populations, we do think it would be beneficial to incorporate an element specific to the CCI population that resides in institutions. That element would include a question concerning the beneficiary's interest in returning to the community and further questions that specifically relate to identifying the level of a beneficiary's health and functional needs during and after a desired and appropriate transition to the community.

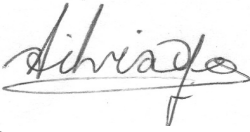
7. Clarification in Timeline Charts

At pages 3 and 6, Day 31 to Day 40 in the Section One (High-Risk) chart and Day 31 to Day 60 in the Section Two (Low-Risk) chart: Change the required activity in the charts so that plans are required to send a mailing to the beneficiary about the HRA "if the plan is unable to complete the HRA in person/ by telephone *or schedule an in-person HRA that falls within the required timeline.*" [Emphasis on suggested addition] This should reduce redundancy and confusion around a beneficiary getting another mailing even though she or he has already scheduled an HRA that will fall outside of Day 40 (high-risk) or Day 60 (low-risk).

Thank you again for the opportunity to provide comments on the draft HRA Health Plan Guidance. Our understanding of the HRA is that it will be the basis for a beneficiary's

personal care plan. As such, the more resources that are expended at this point to achieve accurate and complete information on a beneficiary's needs, the more likely those needs and the goals of the CCI will be effectively met over time. We did not raise the issue of the state's monitoring and enforcement of its final HRA guidance since the particular document we are reviewing is directed at health plans, but both monitoring and enforcement will be needed to ensure that state and consumer interests are met during the HRA process. We would be more than happy to discuss any of the above recommendations or answer questions on any aspect of our comments. As virtually all of our comments were not directed at particular sections of the policy documents we did not use the comment template provided by DHCS for the purpose.

Yours Truly,

A handwritten signature in black ink, appearing to read 'Silvia Yee', with a horizontal line drawn underneath the signature.

Silvia Yee
Senior Staff Attorney